

<b>Case Number:</b>	CM15-0108741		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	02/03/2015
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Arizona, California  
 Certification(s)/Specialty: Family Practice

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 39 year old male who sustained an industrial injury on 2/3/15 when he lifted a piece of plywood he felt a pop in his low back followed by significant low back pain. He was medically evaluated and had an MRI of the lumbar spine showing significant central disc protrusion and contained herniation. He currently complains of low back pain. On physical exam there is decreased range of motion of the lumbar spine with tenderness over the paravertebral (L4, L5) and sciatic notch. Medications are Colace, Tramadol, ibuprofen and Flexeril. Diagnoses include lumbar or lumbosacral disc degeneration; thoracic or lumbosacral neuritis or radiculitis; radicular syndrome, unspecified; lumbosacral spondylosis; sciatica. Treatments to date include medications; physical therapy. Diagnostics include MRI of the lumbar spine (3/31/15) showing small disc bulge and small posterior disc herniation. In the progress note dated 4/30/15 the treating provider's plan of care includes requests for bilateral L5 transforaminal epidural injections along with bilateral 4/5 and 5/S1 facet joint injections in an effort to get him back to work sooner rather than later.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Bilateral L5 transforaminal epidural injections:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural injections Page(s): 47.

**Decision rationale:** According to the guidelines, the criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. In this case, the claimant does not have radicular findings on exam and the MRI does not show cord compression. The justification provided was to return to work sooner. This is not an indication for an ESI and the request is not medically necessary.

**Bilateral L4/5, 5;S1 facet injections:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ODG low back pain and pg 36.

**Decision rationale:** Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should last at least 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a "sedative" during the procedure. 8. The use of IV sedation (including other agents such as

midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005) 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion In this case, the claimant does not have radicular symptoms nor MRI findings of it, but the claimant has not completed all the PT sessions and recent exam notes did not indicate pain levels in response to medications to justify the need for facet blocks. In addition, the ACOEM guidelines do not support invasive procedures due to their short-term benefit. The request for a facet injection is not medically necessary.